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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Kenneth Benjamin Hughes, M.D. 12732 West Washington Boulevard, Suite B Los Angeles, CA 90066 Physician's and Surgeon's Certificate A 115178, Respondent.	Case No. 800-2015-016600 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On December 17, 2010, the Board issued Physician's and Surgeon's Certificate number A 115178 to Kenneth Benjamin Hughes, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2018, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

CASE SUMMARY

Patient A.V.[1]

8. On June 27, 2014, Patient A.V. was seen by Dr. B. and Respondent for consultation for fat grafting to the buttocks. She previously had breast implants replaced by Respondent on December 17, 2012. The consultation form was only filled out with name, hernias none, and a surgical plan. There was a note from Respondent that he thinks she would have enough fat if he also liposuctioned the arms and thighs. On June 30, 2014, hematology lab results were within normal limits.

9. On July 29, 2014, Patient A.V., signed a detailed consent for the surgery. There were undated preoperative photos that were non-contributory. A history physical form was

[1] Patients names are reduced to initials for privacy.

completed just prior to surgery. A nursing preoperative assessment listed a weight of 135 pounds.

10. On August 4, 2014, the surgery was performed. The operative report listed Respondent as the surgeon and describes infiltration of four (4) liters (L) of tumescent (25 cc of 1% lidocaine with epinephrine and 1 ampule of 1:1,000 epinephrine/L) into the upper arms, medial thighs, back and flanks, liposuction of 4000 cc from these areas, and injection of 720 cc supernatant fat separated by gravity into each buttock using a blunt cannula via a central port above the gluteal crease under general endotracheal intubation anesthesia. Anesthesia began at 9:20 a.m. and surgery began at 10:15 a.m. At 11:52 a.m., after the fat injections were completed and she was placed back in the supine position, patient A.V. developed bradycardia to 40 beats per minute (bpm), with a drop in end tidal CO2 from 32 to 8 and lost a measureable blood pressure without an initial corresponding drop in oxygen saturation. Following injections of epinephrine and atropine there was no electrical cardiac activity and a code was called and chest compressions were initiated. Sodium Bicarbonate was given at 11:59 a.m. and "911" was called. The records do not indicate how much IV fluid was given. Patient A.V. was taken by ambulance to Southern California Hospital at Culver City, pulseless in V-fib. She did not respond to cardioversion attempts and tPA infusion and was pronounced dead at 1:24 p.m.

11. An autopsy found 2200 gm of (solid clotted) blood was present in the abdominal cavity arising from a traumatic wound of the right internal iliac artery. Both kidneys were pale, consistent with massive blood loss. A focal right atrial wall hemorrhage was present from chest compressions. The cause of death was deemed accidental puncture of the right internal iliac artery with exsanguination. At his interview, Respondent stated it was physically impossible -- anatomically impossible -- for him to have injured the artery

because he would have had to pass the cannula through bone. This puncture was most likely due to overzealous fat injection to the buttocks with the cannula passing from below anterior to the sacrum via the ischiorectal fossa (whose posterior wall is the gluteus maximus) puncturing the internal iliac artery caudal to where it branches off the common iliac artery near the level of the lumbosacral junction. An arteriogram of the iliac vessels establishes that the puncture is not impossible. Respondent's explanation only holds if the cannula is solely passed perpendicular to the skin surface and plane of the legs. However, Respondent's operative report describes cannula entrance near the gluteal fold and therefore parallel to the plane of her legs, i.e. the operating room table.

Patient Y.W.

12. On March 28, 2014, Patient Y.W. visited Respondent in consultation for liposuction, fat grafting to the buttocks and fat grafting to the nasolabial folds. She signed detailed consents for liposuction and fat injections to the buttocks at that visit. Undated preoperative photos show a protuberant abdomen with a small infraumbilical pannus whose fold extends laterally to the anterior axillary lines and folds of excess lower back skin. There was a fold that extended across the entire back at the upper sacral level and a fold on either side at the mid-lumbar level that did not meet across the midline. The buttock area has a square frame and square muscle/soft tissue configuration. On March 28, 2014, hematology and chemistry lab results were within normal limits. On March 27, 2014, she paid $5,000 and on April 3, 2014, she paid an additional $4,000 towards surgery.

13. On April 11, 2014, the procedure was performed. The operative report listed the surgeon as Respondent. It described infiltration of 5 L tumescent (25 cc of I% lidocaine with epinephrine and 1 ampule of 1:1,000 epinephrine/L) into the abdomen, back and flanks. It also described liposuction of 4,000 cc from these areas, and injection of 1,200 cc

supernatant fat separated by gravity into each buttock using a blunt cannula via a central port above the gluteal crease under general endotracheal intubation anesthesia. A nursing preoperative assessment listed a weight of 165 pounds (74.8kg). Surgery started at 11:45 a.m. and was completed at 1:55 p.m. Vital signs were stable throughout surgery. She was released to go home at 4:00 p.m. There is a prescription in the records for antiemetics dated April 11, 2014. After she returned home, Patient Y.W. called Respondent and complained of pain, nausea and fever. She was instructed by staff to buy and take over the counter medications. The notes say she again called that night complaining of pain and was told pain was normal after surgery and was advised to go the emergency room if she was concerned.

14. On April 13, 2014, patient Y.W.'s mother called Respondent and said Y.W. was vomiting. She was instructed to take Y.W. to the emergency room. The same day, Y.W. presented to the Kaiser Permanente emergency room with complaints of abdominal pain, nausea, vomiting, fever and inability to keep down her oral pain medication since undergoing the surgery. Due to the life threatening danger of her injury, this may have saved her life. On exam she was tachycardic to 137 heart beats per minute (BPM), with abdominal tenderness but no rebound or guarding. Infraumbilical and bilateral lower flank erythema were noted. Her white blood cell count was elevated at 13.9 with slight hyponatremia, hypokalemia and hypochloremia. AST, total bilirubin and lactate levels were elevated. Her heart rate came down to 110 BPM with 2 liters of IV fluid and she was admitted for cellulitis with sepsis. Blood cultures eventually grew out Enterococcus faecalis. A CT scan showed decompressed distal ileum consistent with small bowel obstruction, intraperitoneal free air, subcutaneous emphysema and mild ascites.

15. On April 14, 2014, patient Y.W. was taken to the operating room. Initial laparoscopy showed a suprapubic fascia injury and leakage of bowel contents into the rectus

sheath. On conversion to an exploratory laparotomy, about 10 jejuna enterotomies were found in the mid-distal jejunum over a section of bowel spanning roughly 50 cm (which were resected and the bowel ends primarily anastomosed). Eight superficial serosal injuries of the proximal small bowel were primarily repaired, a cecal perforation with a 2x2 cm area of necrosis was resected as an ileocecectomy with primary anastomosis and some necrotic right rectus muscle/sheath was resected. There are photos in the record showing the perforated bowel and necrotic cecum. The bowel was edematous precluding closure so the abdominal wall was left open with a wound vacuum applied. Intraoperative peritoneal fluid cultures eventually grew out lactobacillus and candida albicans. The operating surgeon noted that Respondent was contacted.

16. Patient Y.W. remained in the ICU on ventilatory support for her open abdomen as well as TPN IV feeding until April 21, 2014. She was placed on antibiotics via a PICC line for the duration of her hospitalization. She underwent delayed closure of the abdomen and debridement of necrotic right lower rectus muscle leaving a fascia defect that was bridged by covering the exposed bowel with BioA mesh on April 17, 2014.

17. An April 20, 2014 CT scan did not show any intra-abdominal or pelvic abscesses. On the surgical floor she had persistent leukocytosis, so another CT scan was performed on April 25, 2014. It showed bilateral large infected seromas above the fascia in the abdomen and pelvis. These were drained by interventional radiology under ultrasound guidance.

18. On April 30, 2014, patient Y.W. finally recovered and was discharged home on oral antibiotics and antifungal medication. She also had multiple blood transfusions during her hospital stay. Respondent perforated her abdominal wall and bowels while performing liposuction of the abdomen and proceeded to seed the intraperitoneal space as well as the abdominal wall with gastrointestinal bacteria and fungus on the cannula.

19. At his interview, Respondent stated that fascia perforations from liposuction were common and this was covered in the consent form. Respondent called patient Y.W. multiple times while she was at Kaiser and tried to visit her at the hospital but she did not want to see or talk to him. Between April 28, 2014 and May 27, 2014, Respondent documented multiple harassing calls from Y.W. On June 6, 2014, he documented calling detectives to start a criminal investigation. Y.W. subsequently developed a hernia that was repaired in June 2015 at Harbor UCLA.

Patient R.Z.

20. On May 17, 2011, patient R.Z. was first seen for filler injections. On December 29, 2011, he was medically cleared for liposuction surgery by Dr. R. He was given prescriptions for postoperative antibiotics and pain medication by Dr. B. on that day. On December 30, 2011, R.Z. signed detailed consent forms for Respondent to perform liposuction of the abdomen, flanks and back. R.Z. paid $4,000.00 towards surgery. R.Z.'s undated preoperative photos show a slightly protuberant abdomen without any abdominal pannus, smooth flank contours down to the hips, no excess love handles fat and mild excess fat above the posterior iliac crests. It was not clear from the photos how much the abdominal prominence is due to lax muscle vs. excess skin and there is no physical exam note of skin pinch thickness or a photo with the abdominal muscles pulled in to aid in the analysis.

21. On January 4, 2012, the procedure was performed. The operative report listed Respondent as the surgeon. It describes infiltration of 5 L of tumescent solution (25 cc of 1% lidocaine with epinephrine/L) and aspiration of 5 L from the abdomen, flanks and back under general anesthesia. The operative time was 1 hour 10 minutes. Undated postoperative photos show periumbilical radiating skin folds but no supra or infraumbilical pannus, slightly prominent love handles areas and 2 crescents of mildly redundant skin above the right hip.

22. Medical notes were dated: January 5, 2012, and January 19, 2012 (with aspiration of a 450 cc seroma). Additional medical notes were dated January 20, 2012, January 23, 2012, January 26, 2012, February 14, 2012, February 23, 2012, and April 10, 2012. These

notes were all written and signed by someone other than Respondent without a co-signature. It is not even clear that Respondent saw the patient at those visits. At his interview Respondent could not explain this, other than he was new in his practice and had aspirated a 700 cc seroma from this non-compliant patient within days of surgery.

23. On April 17, 2012, Respondent saw him for a 3 month follow up. In his May 15, 2012 note, Respondent described the patient as being unhappy with the result and previous hematoma and seroma evacuation. At his interview Respondent said he saw the patient multiple times, even on weekends, to aspirate seromas but none of this is memorialized in the record. On May 15, 2012 he signed a consent for Dr. B. to perform revision liposuction and he was given prescriptions for postoperative antibiotics and pain medication by Dr. B. On August 28, 2012, R.Z. paid $75.00 for copies of his records.

24. On October 26, 2012, in a letter to R.Z., Respondent summarized the two (2) operations he performed and the plan for a delay procedure and some form of tummy tuck. The records of that procedure including its consents are not in the reviewed materials.

Patient T.W.

25. Patient T.W. – also known as M.G. -- was a 43-year-old female with hypertension interested in liposuction and Brazilian butt lift fat injection. On July 18, 2015, she first saw Respondent at which time she used care credit to pay $10,000 towards surgery. On the same day, chemistry blood tests were found to be within normal limits and hematology tests were only notable for microcytosis. On July 23, 2015, she signed detailed consents for abdomen, flank and back liposuction with buttock fat injections by Respondent.

26. On July 23, 2015, the procedure was performed. Her initial blood pressure was 164/100 on the day of surgery. After over 50 minutes of general anesthesia, her blood pressure was brought down to 140/95, with preinduction oral Klonopin and post induction IV versed, Demerol, propofol and labetalol. Respondent then began surgery and the systolic pressure remained below 120 for the remainder of surgery. Two (2) hours and thirty-five (35) minutes into surgery, while still in the prone position having fat injected into her

buttocks, she developed a cardiac arrhythmia, her blood pressure dropped to 60/35 and a heart rate of 40 bpm followed by decreasing oxygen saturation. Surgery was terminated, anesthesia gases were discontinued and the patient turned into supine position with the endotracheal tube in place on 100% oxygen. The rhythm then changed to multifocal PVCs with a heart rate of 40 bpm and no obtainable blood pressure. A code was initiated with chest compressions, epinephrine, ephedrine, atropine and bicarbonate and 911 was called. She was taken by ambulance to Southern California Hospital at Culver City and pronounced dead at the hospital. There is no operative report or documentation of the tumescent solution composition in the records provided.

27. On August 3, 2015 autopsy findings were two 0.5-inch abdominal wall defects just inferior to the left hemidiaphragm, rib fractures from chest compressions, left posterior frontal calvarium periosteal hemorrhage and 150 cc of intraperitoneal blood from soft tissue injury around the duodenum. These injuries were all likely due to resuscitative attempts. Post mortem toxicology detected therapeutic levels of lidocaine, meperidine and ephedrine. Microscopic examination of the lungs showed fat/adipocytes in the large and small blood vessels of the lungs. The cause of death was listed as fat embolism. At his interview Respondent explained this by citing other confirmed deaths by the same cause with other surgeons.

Patient N.L.

28. On October 22, 2015, Patient N.L. saw Respondent for a consultation for buttock implants. She had previous buttock implants placed in Mexico that became infected and had to be removed. The initial records are sparse and basically only state: (1) buttock implants, (2) no inferior buttocks, (3) 400 cc round buttock implants, Implant tech I 0,500. There was also a small diagram indicating where the implants sit in the buttocks. The surgical consultation sheet itself is blank except for her name. October 23, 2015, hematology and chemistry blood tests were within normal limits.

29. On November 18, 2015, procedure was performed. The operative report described her as being aware that given her previous infection and choice of large implants she would again

be at high risk of infection/revision. The procedure section described an incidental Bovie burn of the buttock skin by a defective Bovie, intergluteal incision, creation of bilateral intramuscular pockets, removal of a drain from her previous surgery, antibiotic irrigation of the pockets, insertion of the buttock implants and closure. The operative time was 1 hour 33 minutes. Anesthesia and surgery center consents were signed the same day. There is no consent specific to surgery or buttock implants in the reviewed materials.

30. There was an unsigned history and physical dated November 19, 2015, though the anesthesia record is dated November 18, 2015. At his interview Respondent said that he wanted to place drains in this case, but she was adamant about not having drains so he honored her request. Preoperative photos dated November 18, 2015 show slight asymmetry with a more ptotic left than right buttock, an A-shaped frame with V-shaped muscle/soft tissue, mild to moderate pelvic tilt, muscle point of maximal projection below the level of the symphysis and slightly prominent saddle bag areas (left more than right). Intra-operative photos dated November 18, 2015, show removal of a retained foreign body, the end of a Jackson-Pratt Drain (JP drain). The discharge instruction sheet signed by her escort listed no strenuous activity for an unspecified period of time, no aspirin or ibuprofen, dressing instructions and follow up. It is a general postoperative instruction sheet that was not specific to buttock implants. There is no mention of not sitting on the implants.

31. Postoperative photos dated November 24, 2015 show a more prominent buttock with a higher muscle point of maximal projection. The right buttock is still slightly more ptotic and there is a visible burn on the right buttock near the midpoint of the inter-gluteal cleft. There was no drainage, infection or fluid collection at that office visit. She did not show up for a November 30, 2015, appointment and there is some implication that she was travelling out of town within two (2) weeks of surgery.

32. At the December 1, 2015 visit there was serosanguinous non-purulent drainage from the right buttock via the incision line but no palpable fluid collection in the buttock. She was non-compliant with ace wraps and was advised to continue them. She apparently did not show for a December 8, 2015 visit and was called. She returned the call December 9, 2015, "cursed out"

Respondent for 30 minutes and then agreed to have drains placed. She called again December 10, 2015 for further explanation regarding drain placement.

33. A December 10, 2015 operative report describes, reincising the intergluteal cleft, removal of another piece of JP drain from her Mexico surgery from the right buttock, suture pexy of the right capsule to treat ptosis, antibiotic irrigation, placement of another drain and closure. There was no consent for the December 10, 2015 surgery in the reviewed materials. She called again December 11, 2015 and had another 30-minute rude cursing conversation with Respondent.

34. At a December 15, 2015 visit, the drains placed on December 10, 2015 were working. Photos dated December 18, 2015 show 2 JP drains exiting the intergluteal cleft. An MRI was ordered on December 21, 2015, which reported no infection or fluid collection, i.e. was non-contributory. At his interview Respondent stated that he reviewed the non-contributory MRI's with her. She missed a December 28, 2015 appointment. Respondent ordered x-rays and ultrasound of the right buttock on January 28, 2016.

35. Patient N.L. showed up at Respondent's office on February 2, 2016, without an appointment demanding to be seen. She complained of pain with drainage and requested a refund and more surgery by Respondent until she was satisfied. Respondent tried to refer her to another surgeon but she stated that she wanted her money back and did not want further surgery.

36. Patient N.L. returned February 8, 2016 with the same demands and police were called to remove her from the premises. Respondent's drains were removed at some point but there is no documentation of their removal and it is not clear if he or she removed the drains. At his interview Respondent stated that he did not remember when the drains were removed but said that he did remove them.

37. In his interview he described receiving a call from an emergency room where she presented after trauma to the buttock implant(s). He spoke to the doctor and said he offered copies of the records but the doctor did not want them and presumably removed the implant(s). He also said that he refunded her all that she had paid for the surgery. She claimed to have hired a lawyer, Mr. B.K., in February 2016 and furnished a letter from him requesting records from Respondent. Respondent's lawyer, Mr. K., who knows Mr. B.K., said this letter was not on B.K.'s letterhead,

did not have Mr. B.K.'s correct office address, did not include a release of records consent and was never seen by him or Respondent prior to the subject interview.

38. On April 4, 20 16, patient N.L. apparently saw Dr. J.M. in Torrance who requested copies of records from Respondent on April 8, 2016. She filed a complaint alleging substandard care, failure to provide her with copies of her medical records, forging of medical records and destruction of medical records. She stated that she had tried to get copies of her records since November 25, 2015 (15 days before her second operation by Respondent) but that Respondent would not respond or accept her phone calls. She claimed that his removal of the right implant at the December 10, 2015 surgery and then placing it back in her buttock with drains caused a hematoma/blood clot/blood vessel damage leaving her with a large obvious right buttock indentation. She stated that Respondent stopped treating her a week later and the hematoma became infected with exposure of the implant. Respondent claimed that he never received a request for records from her and all she did was scream and curse when she came into his office. He stated the only record request he had was from the California Department of Consumer Affairs, Division of Investigation and he complied. Respondent stated that patient N.L. took him to small claims court and he won this case, so she refiled and won the second time because he did not appear at the trial.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

39. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he was grossly negligent in the care and treatment of his patients. The facts and circumstances alleged above are incorporated here as if fully set forth. Also the circumstances are as follows:

A. On August 4, 2014, Respondent punctured the right internal iliac artery of patient A.V. while performing a procedure including injecting fat into her buttocks.

B. On August 12, 2014 and August 13, 2014, Respondent abandoned patient Y.W. over the weekend while she had multiple bowel injuries.

C. On July 23, 2015, Respondent commenced elective cosmetic surgery on patient T.W., who had uncontrolled hypertension going into surgery.

D. On July 23, 2015, Respondent injected fat into T.W.'s venous system causing death from fat embolism.

E. Respondent failed to obtain signed consents from patient N.L. for the surgeries dated November 18, 2015 and December 10, 2015.

SECOND CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

40. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of his patients. The facts and circumstances alleged above in paragraphs 8 through 38 are incorporated her as if fully set forth. The circumstances are also as follows:

A The facts and circumstances in the First Cause of Discipline are incorporated as if fully set forth.

B. On August 4, 2014, April 14, 2014 and July 23, 2015, Respondent failed to complete and file an Outpatient Surgery – Patient Death Reporting Form and/ or a Patient Transfer Form regarding patients A.V. and T.W.

C. Respondent omitted documentation of his communications including email and follow up with patient R.Z. from her medical records after April 24, 2015.

D. On or about July 23, 2015, Respondent failed to document patient T.W.'s liposuction infusate composition.

E. On July 23, 2015, Respondent failed to create an operative report for patient T.W.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

41. Respondent is subject to disciplinary action under Code section 2266, in that he failed to maintain adequate and accurate records relating to the provision of medical services to patients.

The facts and circumstances alleged above in paragraphs 8 through 39 are incorporated her as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

42. Respondent is subject to disciplinary action under Code section 2234, in that he engaged in unprofessional conduct in his care and treatment of his patients. The facts and circumstances alleged above in paragraphs 8 through 40 are incorporated here as if fully set forth. The circumstances are as follows: Respondent failed to provide patient N.L. with silicone implant information prior to the November 18, 2015 surgery and noting this in the medical record.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 115178, issued to Kenneth Benjamin Hughes, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: September 26, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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